

Land marks & Places in Strawberry Valley

Dominguez Escalante Monument
Mill A — Sawmill operation

40 Dam
acres

Mill B

Don & Bob
Clyde
Cornels

Strawberry Canal & Portal

Fish Trap Station

Stinking Springs

Bull Spring

Soldier Creek Dam

Store — Bert Lindsay

Jim Burbidge Snack Bar

Strawberry Dam

Tunnel
canal
Diamond Fork Canyon

Strawberry Ridge

Cattle yards — Clyde

Frank Malsen's Boat Camp

Chas Woodbury " "

Strawberry Camp —

Strawberry River

Sugar Springs

Buildings @ Bill's Snack Bar

Siemmer Military Camp

Forrest Service Station

Anderson Timbering operation

The Knolls —

Windy Ridge

Million Dollar Cut

Geo Frisby Cut

Water Hollow Tunnel

Soldier Creek Dam

Strawberry Dams

& Portal

Trout Creek

Chicken Creek

creek

Vestus Maloney Development

Head of Diamond Fork Canyon

Soldier's Head

Ace Bethers

List of
Springs:
Bull
Stinking

UNITED BUSINESSMENS INSURANCE TRUST

Medical Claim Form
MAIL TO: P.O. BOX 298, SALT LAKE CITY, UTAH 84110

FOR PROMPT PAYMENT
OF CLAIM REFER TO
INSTRUCTIONS ON
REVERSE SIDE.

Complete all items #1 - 11. Attach all itemized bills.

1. EMPLOYER'S NAME		2. GROUP NUMBER	
3. NAME OF EMPLOYEE	SOC SEC NO	DATE OF BIRTH OF EMPLOYEE	PHONE NO
4. STREET NUMBER	CITY AND STATE	ZIP CODE	
5. NAME OF DEPENDENT (IF PATIENT)		RELATIONSHIP TO EMPLOYEE	DATE OF BIRTH OF PATIENT
6. DATE ACCIDENT OR SICKNESS BEGAN	IS CLAIM DUE TO AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	IS CLAIM A RESULT OF A JOB RELATED INJURY? YES <input type="checkbox"/> NO <input type="checkbox"/>	PHYSICIAN'S NAME
7. NATURE OF SICKNESS, INJURY DIAGNOSIS OR MEDICAL CALL	NAME AND ADDRESS OF SPOUSE'S EMPLOYER (IF NOT EMPLOYED WRITE "NOT EMPLOYED")		
8. NAME OF SPOUSE			
9. ARE YOU OR YOUR DEPENDENT COVERED UNDER ANY OTHER GROUP INSURANCE, HEALTH MAINTENANCE ORGANIZATION, OR GOVERNMENT PLAN WHICH WILL ALSO PAY FOR ANY OF THE MEDICAL EXPENSES OF THIS CLAIM? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, GIVE NAME, ADDRESS & POLICY NUMBER OF INSURANCE COMPANY PROVIDING BENEFITS.	NAME AND ADDRESS		
10. IF PAYMENT IS TO BE MADE TO PHYSICIAN SIGN BELOW		11. PATIENT OR PARENT MUST SIGN BELOW	
AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the undersigned Physician, otherwise payable to me for his services as described below, but not to exceed the reasonable and customary charge for those services. SIGNED (COVERED PERSON) SIGN ONLY IF PAYMENT IS TO GO TO DOCTOR DATE		AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any Licensed Physician, Medical Practitioner, Hospital, Clinic or other medical or medically related facility, insurance company or institution or person, that has any records or knowledge of my health to release that information to United Businessmens Insurance Trust. A photocopy of this authorization shall be as valid as the original. SIGNED DATE	

Be sure to complete all items. If you do not your claim may be delayed.

PART II TO BE COMPLETED BY PHYSICIAN

PATIENTS NAME		AGE	IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>
DIAGNOSIS AND CONCURRENT CONDITIONS			
DATE SYMPTOMS FIRST APPEARED		DATE PATIENT FIRST CONSULTED	IF PATIENT WAS REFERRED BY ANOTHER PHYSICIAN PLEASE NAME
PREGNANCY YES <input type="checkbox"/> NO <input type="checkbox"/>	IF YES, APPROXIMATE DATE PREGNANCY COMMENCED	HAVE YOU SUBMITTED THIS CLAIM OR DO YOU PLAN TO TO SUBMIT THIS CLAIM TO ANOTHER COMPANY? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES - NAME CO	
REPORT OF SERVICES (OR ATTACH ITEMIZED BILL)			
DATE OF SERVICES	PLACE OF SERVICE	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	PROCEDURE CODE
TOTAL \$		CHARGES \$	
DATE OF SERVICE		DATE OF SERVICE	
PHYSICIAN'S NAME (PRINT)		SIGNATURE	
DATE		CITY & STATE	ZIP
STREET ADDRESS		TELEPHONE	